# VISION SCREENING CERTIFICATE

This form may only be used by applicants for class D or M learner's permits or licenses. This form must be completed by an optometrist or by a physician: a medical doctor who is licensed to practice in the Commonwealth of Massachusetts.

Name of Applicant **Type or Print** License number

I hereby authorize the physician or optometrist completing this form to discuss its content with representatives of the Registry of Motor Vehicles.

Applicant's Signature Applicant's Phone (area code & number) Date

**********

**VISION SCREENING DATA**

| 1. VISUAL ACUITY (Snellen) | WITHOUT RX | WITH RX | WITH BIOPTIC TELESCOPE (CLASS D LICENSES ONLY) | |
|---|---|---|---|---|
| Right Eye (OD) | 20/ | 20/ | 20/ | (through telescope) |
| Left Eye (OS) | 20/ | 20/ | 20/ | (through carrier lens) |
| Both Eyes (OU) | 20/ | 20/ | 20/ | (through other lens) |

DO NOT USE QUALIFIERS SUCH AS + OR - SYMBOLS, OR THE COUNTING FINGERS ("CF") DESIGNATION TO INDICATE VISUAL ACUITY.

2. TOTAL HORIZONTAL VISUAL FIELD - Both Eyes Combined: _____ (Record in Degrees).
**Suggested Target size to be used: 10mm.

3. Are glasses and/or contact lenses needed for driving?

_____ YES _____ NO (Check One)

(IF "YES," QUESTION 1 SHOULD INDICATE VISUAL ACUITY "WITH RX")

4. Are bioptic telescopic lenses needed for driving?

_____ YES _____ NO (Check One)

(IF "YES", QUESTION 1 SHOULD INDICATE VISUAL ACUITY "WITH BIOPTIC TELESCOPE" AS WELL AS "WITH RX")

a. If "Yes," the bioptic telescope:

| | | | |
|---|---|---|---|
| Is Monocular? | _____ YES | _____ NO | (Check One) |
| Is Fixed focus? | _____ YES | _____ NO | (Check One) |
| Is No greater than 3X? | _____ YES | _____ NO | (Check One) |
| Is Spectacle-mounted and an integral part of the lens? | _____ YES | _____ NO | (Check One) |
| Does not occlude the line of sight or other eye? | _____ YES | _____ NO | (Check One) |

NOTE: TO OBTAIN A LICENSE, "YES" MUST BE CHECKED FOR ALL OF THE CRITERIA IN 4a.

5. Is the applicant's vision characterized by:

Unresolvable Diplopia? _____ YES _____ NO (Check One)

NOTE: TO OBTAIN A LICENSE, "NO" MUST BE CHECKED TO QUESTION 5.

6. Can the applicant distinguish red, green, and amber colors? _____ YES _____ NO (Check One)

NOTE: TO OBTAIN A LICENSE, "YES" MUST BE CHECKED TO QUESTION 6. (OVER)

Listed below are the conditions, treatment, or medication plan which the applicant must follow in order to maintain the validity of my professional opinion:

_____

_____

A license is valid for five (5) years.
Do you think that the applicant should be re-evaluated by the Registry during that time period? ___ YES ___ NO (Check One)
If "YES," please complete:

"I recommend a re-evaluation on _____ (month/year) due to _____ (condition/ disease) and _____ (other factors/comments)."

VISION SCREENING ANALYSIS

Provided said applicant follows the conditions and treatment prescribed on this certificate, in my professional opinion the operator meets the minimum visual standards required by the Commonwealth of Massachusetts (described below) and therefore is visually qualified to safely operate the following vehicle(s):

| YES | NO | |
|---|---|---|
| ( ) | ( ) | Ordinary passenger vehicles not being operated to transport passengers for hire, with the |

following exceptions (if any)_____.

I, the undersigned physician or optometrist, agree to keep a copy of this Vision Screening Certificate in my office for a one-year period following the date of the screening.

*I hereby certify that the information provided herein is true, accurate, and complete,*

_____ _____
(MASSACHUSETTS REGISTRATION #) (SIGNATURE OF PHYSICIAN OR OPTOMETRIST)

_____ _____
(DATE OF SCREENING) (PRINTED/TYPED NAME OF PHYSICIAN OR OPTOMETRIST)

_____ **Circle one: M.D O.D.**
(OFFICE PHONE: AREA CODE & #)

**NOTE: THIS CERTIFICATE WILL NOT BE ACCEPTED BY THE REGISTRY AFTER ONE YEAR FROM DATE OF SCREENING. A PHOTOCOPY OF THE CERTIFICATE WILL NOT BE ACCEPTED. ONLY A CERTIFICATE WITH ORIGINAL WRITING WILL BE ACCEPTED.**

**To Be Completed By RMV Personnel Only:**

REVIEWED AT _____ OFFICE ON _____ BY _____

**MINIMUM REQUIRED VISUAL STANDARDS:**

! AT LEAST 20/40 DISTANT VISUAL ACUITY (SNELLEN) IN EITHER EYE, WITH OR WITHOUT CORRECTIVE LENSES, AND NOT LESS THAN 120 DEGREES COMBINED HORIZONTAL PERIPHERAL FIELD OF VISION: ELIGIBLE FOR A LICENSE.

! BETWEEN 20/50 - 20/70 DISTANT VISUAL ACUITY (SNELLEN) IN EITHER EYE, WITH OR WITHOUT CORRECTIVE LENSES, AND NOT LESS THAN 120 DEGREES COMBINED HORIZONTAL PERIPHERAL FIELD OF VISION: ELIGIBLE FOR A LICENSE WITH A "DAYLIGHT ONLY" RESTRICTION.

! FOR BIOPTIC TELESCOPIC LENS WEARERS: AT LEAST 20/40 DISTANT VISUAL ACUITY (SNELLEN) THROUGH THE TELESCOPE, AT LEAST 20/100 DISTANT VISUAL ACUITY (SNELLEN) THROUGH THE CARRIER LENS, AT LEAST 20/100 DISTANT VISUAL ACUITY (SNELLEN) THROUGH THE OTHER LENS, AND NOT LESS THAN 120 DEGREES COMBINED HORIZONTAL PERIPHERAL FIELD OF VISION: ELIGIBLE FOR A LICENSE WITH A "DAYLIGHT ONLY" RESTRICTION, PROVIDED THE BIOPTIC TELESCOPIC LENS MEETS THE CRITERIA DESCRIBED ON THE FRONT OF THIS DOCUMENT.